

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN0106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 11/17/2010
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - WINDWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 220 LONGMIRE RD CLINTON, TN 37718		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
(N 000)	Initial Comments  An annual Licensure survey and complaint investigation #26477 was completed on October 27, 2010 through November 2, 2010 at Golden Living Center Windwood. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	(N 000)			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

(X6) DATE

SEQ712

If continuation sheet 1 of 1